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An Integrated Approach to the LTC Industry

PPS ALERT FOR LONG-TERM CARE

CMS launches five-star rating system

Providers need to communicate true quality to the public

Now that consumers can easily access nursing home quality ratings, long-term care providers say the industry needs to communicate the aspects of nursing home quality that the five-star rating system doesn't capture.

In December 2008, CMS posted its five-star quality rating system on the Nursing Home Compare Web site. The rating system uses data from surveys, staffing rates, and 10 quality measures to calculate star ratings, ranging from one to five.

When the rating system was unveiled, many long-term care providers said the system oversimplified nursing home quality and didn't account for customer satisfaction. Regardless of the system's flaws, long-term care providers will still have to live with the five-star rating system. "I think the centers that got five stars should tell all of their families, their staff, and their residents about their successes," says **Barbara Bruhm, RN, BN, HSM,** executive director of consulting services at Landmark Health in Haverhill, MA. "But the buildings that didn't score well need to tell their story too and explain to families, residents, and staff why they received the rating they did and the actions that they take every day to maintain quality care."

Educating consumers about quality

At a December press conference, Kerry Weems, CMS acting administrator, said he wouldn't tell consumers to eliminate one-star facilities from consideration but would recommend that consumers carefully evaluate those facilities to understand why they received one-star ratings. Weems added that when choosing a facility, no rating system or Web site can substitute for visiting a nursing home and talking with nursing facility management, state ombudsmen, and residents' families.

> **"The biggest miss with the five-star system is that it doesn't measure what we think is a very important measure, and that's customer satisfaction."**
>
> *—Richard C. Bane, MBA, FACHCA*

However, many long-term care providers are concerned that consumers will rely too heavily on star ratings.

"Unless [consumers] really understand the criteria that went into the rating system and the criteria that didn't, they're not going to have all the information to make the best choice for themselves and their family members," Bruhm says. "We need to educate people."

How the ratings work

The five-star rating system's methodology is fairly complex and can be difficult to understand, even for long-term care providers.

> *continued on p. 2*

HCPro

IN THIS ISSUE

p. 4 **Beneficiary notifications**
We give you a complete guide to simplifying the beneficiary notification process at your facility, including a chart of notifications and a quiz.

p. 8 **Compliance programs**
The Office of Inspector General recently released supplemental compliance guidance for nursing facilities. Learn how to get started at your facility.

p. 10 **MDS 3.0 question of the month**
Find out what your peers are asking about at MDSCentral.

p. 11 **PPS Q&A**
Rena R. Shephard, MHA, RN, RAC-MT, C-NE, answers questions about respiratory therapy, ICD-9 coding, and more.

Five-star rating

< continued from p. 1

In a nutshell, facilities receive one to five stars for each of the following domains:

- The **health inspection** domain is calculated from the three most recent years of surveys, as well as results from complaint investigations in the previous three years. Deficiencies are weighted according to scope and severity, and the number of repeat revisits required to correct a deficiency is considered.
- The **staffing** domain is based on the number of RN and overall staff hours (this combines RN, licensed practical nurse, and nursing assistant hours) each resident receives per day. The score is adjusted for case-mix differences.
- The **quality measure** domain is derived from long- and short-stay quality measures from the MDS. For long-stay residents, the system evaluates what percent of a facility's residents:
  - Experienced activities-of-daily-living (ADL) decline
  - Experienced decline of mobility
  - Have high-risk pressure ulcers
  - Have catheters
  - Are physically restrained
  - Have urinary tract infections
  - Have moderate to severe pain

For short-stay residents, the rating system evaluates what percentage of residents have:

- Pressure ulcers
- Delirium
- Moderate to severe pain

The system uses the following calculation to determine a nursing home's overall star rating:

1. Start with the facility's health inspection rating.
2. For facilities with a four- or five-star staffing rating, add one star to the health inspection rating. For facilities with a one-star staffing rating, subtract one star from the inspection rating.
3. For facilities with a five-star rating for quality measures, add one star. For facilities with a one-star quality measure rating, subtract one star.

A facility cannot receive more than five stars or fewer than one star. Additional rules apply to the rating calculation for Special Focus Facilities that have not graduated and facilities that received a one-star health inspection rating. For a detailed explanation of the calculation, find CMS' technical users' manual by visiting *www.cms.hhs.gov/CertificationandComplianc* and clicking on the "Five-Star Quality Rating System" manual on the left side of the page. Scroll down to the Downloads section.

Using survey to score facilities

Long-term care industry groups object that the rating system is based on what they call a broken survey system.

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Members of the long-term care industry are concerned that a survey deficiency could skew a facility's rating, says **Sherrie Dornberger, RNC, CDONA, FACDONA,** president of the National Association of Directors of Nursing Administration.

Dornberger offers an example from a facility she worked in. The facility served raisin toast at breakfast, which was extremely popular with residents. However, during a survey, a surveyor turned a toaster upside down and a raisin fell out. The facility received an infection control deficiency.

Most nursing facility staff members understand that a seemingly minor infraction can lead to a survey deficiency that remains on a facility's record for a long time. However, consumers may not be aware of this when viewing a nursing home star rating.

Using ratings to improve

Although imperfect, the five-star rating system offers nursing facilities opportunities to compare themselves to other facilities and improve in certain areas.

Dornberger says she was pleased to see that the system highlights the importance of providing RN hours for resident care and gives facilities a federal benchmark for staffing hours.

Facilities should look at their rating from a performance improvement point of view, Bruhm says. Members of the interdisciplinary team should meet and analyze their facility's ratings: Does the facility have ADL decline? Why does it have a high percentage of catheters? Are we managing residents' continence? Are we aware of regulations and complying with them?

Counting customer satisfaction

Many members of the long-term care industry are disappointed the five-star rating system doesn't account for customer satisfaction.

"The biggest miss with the five-star system is that it doesn't measure what we think is a very important measure, and that's customer satisfaction," explains **Richard C. Bane, MBA, FACHCA,** president of BaneCare, LLC, which operates several nursing facilities in Massachusetts.

In Massachusetts, long-term care providers worked with the state legislature and department of public health to conduct customer satisfaction surveys in 2005 and 2007. In both surveys, nine out of 10 respondents statewide said they would recommend their nursing home to a friend or family members. "To have that kind of performance and to have that not be recognized in a five-star rating is crazy, particularly because the five-star rating is intended to focus on the needs of the consumer," Bane says.

At the December press conference, Weems said CMS would like to include customer satisfaction in the rating system in the future.

Communicating with customers and CMS

Word of mouth is still the No. 1 factor for families and residents choosing a nursing home, but more people are using the Internet to get information about facilities, Bane says.

Providers should encourage people to make sure the Internet is not the only source of information used when selecting a nursing facility. "Matching the needs of the resident with the skill set of the particular nursing home is the most important thing," Bane says. "There's not a consumer Web site nor any information you can get on the Web that can tell you whether nursing home X, Y, or Z is the right place for your mother."

Nursing facilities should tell consumers about measures of quality not included in the five-star system, such as special programs or high customer satisfaction, says Bruhm.

Providers are hoping to work with CMS as a partner to give feedback on how to improve the rating system, says Bane. ■

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Beneficiary notifications: Simplify the process at your SNF

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- State which beneficiary notifications are mandatory
- Identify the rights processes associated with advanced beneficiary notifications (ABN) and expedited determination notices (EDN)
- Name the notices that must be issued under Medicare Part A and Part B
- Explain when the Notice of Exclusion from Medicare Benefits (NEMB) form may be used
- Name the notifications issued under the Expedited Review Process

Beneficiary notifications give Medicare beneficiaries important information about their benefits and protect SNFs from financial liability, but the regulations for the notification process can be confusing. SNFs must issue several kinds of notifications and many facilities have several staff members responsible for notifications.

"A lot of facilities don't have a process for issuing notifications and assume a certain person is doing it," says **Theresa Lang, RN, BSN, RAC-C, WCC,** vice president of clinical consulting at Specialized Medical Services, Inc., in Milwaukee.

Sometimes, when that staff member leaves the facility, beneficiary notification isn't reassigned, and notices may not be issued properly, Lang says.

"It's not until you wind up with a survey problem, demand bill, or a Quality Improvement Organization [QIO] request that facilities realize that the notices aren't being issued correctly," she says.

Avoid survey and financial liability problems by learning which notices your facility must issue and creating a system for issuing beneficiary notifications properly.

Beneficiary notification background

One of the first steps to improving the beneficiary notification process at your facility is understanding which notifications are mandatory and which are optional, says **Claudia Reingruber, CPA,** managing shareholder of Reingruber & Company, PA, in St. Petersburg, FL.

All of the notifications can be found at CMS' Beneficiary Notices Initiative Web page at *www.cms.hhs.gov/BNI.*

SNFs must provide the following kinds of beneficiary notices:

- SNF ABN or SNF denial letters for Part A services
- ABN for Part B services
- EDNs for Part A and Part B

ABNs and EDNs represent two different appeal rights and processes. The EDN gives the beneficiary the right to an expedited review through a QIO, and the ABNs or SNF denial letters give the right to appeal to the fiscal intermediary (FI) using the demand bill process.

For example, if your facility has a resident in a Medicare Part A stay and Part A services are ending, you would issue the SNF ABN or denial letters and an EDN, says Reingruber.

If you have a resident who is receiving therapy under Part B, and the resident's family wants him or her to continue therapy beyond medical necessity, provided the therapy caps have not been met, you would need to issue an EDN and an ABN/ABN-G, she says.

Note: SNFs must begin using the revised ABN in place of the ABN-G beginning March 1, according to CMS officials.

Notifications and the therapy caps

Providers should inform residents they are responsible for all costs of therapy beyond the therapy caps, according to Medicare *Transmittal 1106*. The 2009 cap is $1,840 for physical and speech therapy combined, and $1,840 for occupational therapy.

Transmittal 1106 states that "although use of the NEMB form is not a Medicare requirement, Medicare contractors shall advise providers to use the NEMB form, or a similar form of their own design to inform

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beneficiaries of the therapy financial limitation and the cap exclusion process."

However, the exceptions process is in place for 2009, so residents for whom therapy is deemed medically necessary may receive therapy services exceeding the caps.

Note: The word "should" means it's good practice rather than mandatory. Also, deductibles and coinsurance apply to the therapy caps, so notify beneficiaries well before they approach the limit.

Revised SNF ABN

Part of SNFs' confusion about beneficiary notices results from having to choose from multiple kinds of ABNs when issuing that form of beneficiary notification. When Part A services are ending but the resident will remain in the SNF for custodial care or therapy, SNFs can issue the SNF ABN (form CMS 10055) or one of five SNF denial letters.

SNFs are still awaiting the arrival of a new SNF ABN form, which is expected to replace the use of multiple ABNs. At a December 11, 2008, SNF Long-Term Care Open Door Forum, CMS officials said they hoped the revised SNF ABN would be available this spring or summer.

The revised SNF ABN would require providers to issue only the SNF ABN in conjunction with the appropriate EDN, according to a CMS Town Hall presentation.

Using the NEMB

The NEMB is used when the technical requirements for coverage within a Part A stay, such as a three-day qualifying hospital stay, are not met, Reingruber says. The NEMB is voluntary.

Many long-term care facilities don't complete the NEMB at all, Lang says, adding that although you may not technically be required to give the NEMB, using it is a good opportunity to inform residents and their families about Medicare benefits.

The expedited review process

SNFs are required to notify Medicare beneficiaries of their right to an expedited review process when they expect Medicare coverage of services will end. This process involves issuing EDNs, which may need to be given in addition to ABNs. For more information about when ABNs and EDNs are issued, see "Guide to SNF beneficiary notifications" on p. 7.

The Generic Notice, CMS 10123, must be given to the beneficiary two days before services are discontinued. The Detailed Notice, CMS 10124, must be provided to the beneficiary and the QIO when a beneficiary requests an expedited determination.

Medicare Advantage residents receive different EDNs than Medicare fee-for-service residents. Medicare Advantage residents receive the Notice of Medicare Non-Coverage, which alerts them that Medicare-covered items or services are ending and gives them the opportunity to request an EDN from a QIO.

The Detailed Explanation of Non-Coverage is issued when a QIO review is requested to give more explanation of why coverage is ending.

Beneficiary notification basics

SNF staff members should also understand how to issue notices properly.

Lang says she frequently sees providers using outdated beneficiary notification forms.

If your facility completes beneficiary notices improperly, your notifications could be considered invalid, says **Karen Connor,** director of business operations for Landmark Health in Haverhill, MA.

Connor suggests ensuring that notices have:

- The beneficiary's correct name and Medicare number
- The correct font size, if applicable (ABNs must be issued in a 12-point or larger font)
- Been issued in the proper time frame (e.g., the EDN Generic Notice must be issued two days before services are discontinued)

Facilities should also ensure that staff members are taking the proper steps when contacting residents' responsible parties with notices, Connor says. Beneficiary notices

> ***continued on p. 6***

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SNF

< *continued from p. 5*

contain specific instructions about the proper procedures for contacting responsible parties by telephone and mail.

FIs and Medicare administrative contractors can request beneficiary notices for a process review.

Creating a process for notification

Many facilities don't have a process for issuing beneficiary notifications or have several different people or positions issuing notifications. Ask who is responsible for notifications, Lang says. If no one knows, your facility may not be issuing all of the required notices.

Reingruber suggests assigning notifications to specific staff members. Make sure the people who are responsible for beneficiary notifications are part of your daily Medicare meeting and are aware of when notices should be issued, she says. Everyone at the meeting needs to be on the same page about a resident's Medicare benefits and what notices should be distributed.

Assign the responsibility for beneficiary notices based on your facility's needs. If you have 300-bed facility with two MDS nurses, MDS nurses may issue notifications because they are aware of residents' need for skilled services and benefit periods, Connor says. But that system may not work in a smaller facility where the MDS nurse takes on multiple roles, she says.

Make sure more than one person at your facility can issue notifications, Lang says. If only one person can issue notifications, your facility may not be able to give out notices within the appropriate time frames when that person is not available. ■

Beneficiary notification quiz

Test your understanding of beneficiary notifications with the following quiz. Check your answers on p. 12.

1. Mr. Johnson's son visits the local SNF to ask about placement for his father. Mr. Johnson spent three days in the hospital two weeks ago and has been at home for about a week. His physician would like him to have physical therapy due to the amount of time he was in the hospital. The facility believes Mr. Johnson will qualify for a Medicare Part A stay. On the day of admission, Mr. Johnson walks into the facility without any difficulty or aids and shows no other signs of having a clinical need for therapy. What should the facility do?

a. Explain to Mr. Johnson and his son that Medicare will not likely cover his stay and provide an Advanced Beneficiary Notification (ABN) for rethinking their option
b. Admit Mr. Johnson and bill Medicare for the stay
c. Collect the first month's payment for the SNF stay up-front from Mr. Johnson
d. Report Mr. Johnson's son for fraud and misrepresentation of his father's condition

2. With implementation of the expedited review process, SNFs no longer need to issue a Medicare Notice of Non-Coverage (cut/denial letter) for a resident who will remain in the facility.

a. True
b. False

3. During a care conference, it was determined that Mrs. Montagne could benefit from two more weeks of therapy. Mrs. Montagne decides she does not want to stay and will be going home tomorrow. Which notices are the facility required to give her prior to discharge?

a. Generic Notice
b. Notice of Non-Coverage
c. Both notices
d. No notice is required

4. Mr. Lopez is being cut from Medicare Tuesday, due to lack of a daily skilled service. He will remain in the facility under Medicaid. Which of the following notices must be given to Mr. Lopez prior to being cut?

a. Notice of Non-Coverage (cut/denial letter) or SNF ABN
b. Notice of Exclusion from Medicare Benefits
c. Generic Notice
d. Detailed Notice

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Guide to SNF beneficiary notifications

		SNF ABN Process		NEMB	Expedited Review Process
BNI	**Situation**	**SNF ABN/Denial Letters**	**ABN**	**NEMB (Voluntary)**	**Expedited Determination (ED) Notices**
When to Use?		Medicare Part A services are reduced or eliminated, but the resident remains in the SNF	Medicare Part B services (such as therapy) are discontinued or reduced	An ABN form would not be appropriate. The form is used for benefit category or technical denials.	Medicare-covered items or services are discontinued. The expedited review process gives beneficiaries the opportunity to an expedited review from a Quality Improvement Organization (QIO).
Associated Forms		SNF ABN (CMS 10055) or one of five SNF Denial Letters	Starting on March 1, 2009, SNFs must use the revised ABN for Part B services (CMS R-131). This form replaces the ABN-G (CMS R-131-G)	NEMB SNF(CMS 20014)	The Generic Notice (CMS 10123) must be provided no fewer than 2 days before services are discontinued. The Detailed Notice (CMS 10124) must be provided when beneficiary requests an expedited determination. SNFs must provide different notices for Medicare Advantage
Examples:	Admission to SNF:				
	Beneficiary does NOT meet technical or benefit level criteria (e.g., has not had 3-day qualifying hospital stay or is not admitted within 30 days of hospitalization)			✔	
	Beneficiary MEETS technical requirements: BUT doesn't require DAILY Skiled care (e.g., PT is ordered only 3 days/week); OR has MD orders for care, BUT only requires custodial care	✔			
	Part A Stay Ends Because:				
	SNF (provider) determines that beneficiary no longer requires daily, skilled services:				
	BUT remains in facility for custodial care	✔			✔
	To be discharged from SNF				✔
	BUT will receive Part B therapy at a non-skilled level (e.g., 3 days a week)	✔			✔
	AND all therapy services are terminated				✔
	AND beneficiary is discharged to hospital due to acute illness, OR is transferred to another SNF and will continue Part A coverage, OR is discharged AMA, OR elects hospice benefit				
	Benefit days are exhausted (100 days), BUT still requires skilled care			✔	

> *continued on p. 8*

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Guide to SNF beneficiary notifications

< continued from p. 7

BNI	Situation	SNF ABN Process: SNF ABN/Denial Letters	SNF ABN Process: ABN	NEMB: NEMB (Voluntary)	Expedited Review Process: Expedited Determination (ED) Notices
Examples:	Part B Stay Ends Because:				
	Beneficiary is in a continuing stay, not covered under Part A AND				
	Requires short-term PT (covered under Part B) to address a significant decline in function AND PT ends		✔*	✔	
	Requires short-term PT and OT (covered under Part B) to address a significant decline in function AND OT only ends		✔*		
	Requires short-term PT and OT (covered under Part B) to address a significant decline in function AND both PT and OT end		✔*	✔	
	All skilled Part B services are ending because the provider determines that it is no longer reasonable and necessary (Beneficiary may want to extend therapy BEYOND the date the provider determines is reasonable and necessary)		✔*		✔
	Beneficiary is approaching the therapy cap			✔	
Notes:			* If a physician's order reclarifies that a Part B service is no longer required, it is not necessary for the SNF to issue the ABN. However, if a resident or family member wants to continue the service under private pay, the ABN must be issued.	This form is voluntary. However, issuing a NEMB SNF can be a good opportunity to speak with residents and family members about what services are covered by Medicare.	The expedited review process is distinct from the ABN process. Expedited determination notices often must be issued in conjunction with ABN forms. It went into effect on July 1, 2005.
	Disclaimer: This table is not intended to be used as a comprehensive guide to all situations				

Source: HCPro, Inc., based on CMS regulation and HCPro reporting.

Taking steps toward compliance at your SNF

OIG releases supplemental guidance for nursing homes

If you've justified the reason your SNF does not have a compliance program because you've heard that having no program is better than having unused policies and procedures, you may be headed for trouble.

Although having compliance policies that your facility doesn't apply or enforce may be riskier than having no compliance program at all, the Office of Inspector General (OIG) still won't look favorably upon a facility with no compliance program during an investigation, says **Betsy Anderson, BSA,** vice president of FR&R Healthcare Consulting, Inc., in Deerfield, IL.

Now is a good time for nursing facilities to revisit compliance programs, since the OIG has recently released supplemental compliance program guidance. Although compliance programs are not mandatory, they can protect your SNF from OIG investigations and penalties.

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Fortunately, ensuring that your facility stays in compliance doesn't have to become an enormous project, Anderson says. Start by learning the key elements of a successful compliance program, identifying your facility's risk areas, and incorporating compliance procedures and personnel into your current quality improvement efforts.

Guidance for compliance

In September 2008, the OIG—the enforcement arm of the Department of Health and Human Services—released supplemental compliance guidance.

The guidance, which offers guidelines for nursing facilities that are implementing or evaluating their compliance programs, highlighted the following four risk areas for facilities:

- **Quality of care,** specifically naming sufficient staff levels, comprehensive resident care plans, appropriate medication management, resident safety, and appropriate psychotropic medication use
- **Submission of accurate claims**
- **The federal anti-kickback statute**
- **Other risk areas,** including providing objective information about Medicare Part D prescription drug plans and compliance with HIPAA's privacy and security rules

Don't put compliance on the shelf

The information released by the OIG in September supplements the initial compliance program guidance for nursing homes, which the agency provided in 2000.

The message many facilities got was that having no compliance program was safer than having written policies and procedures collecting dust. Many long-term care providers reacted by not implementing a compliance program at all or by using a one-size-fits-all compliance program, says **Mary Malone, Esq.,** a healthcare attorney at Hancock, Daniel, Johnson & Nagle, PC, in Richmond, VA.

However, neither of those responses are beneficial to nursing facilities, Malone says.

Failing to implement a compliance program may put your facility at risk for OIG investigations. If your facility comes under scrutiny, having a compliance plan may help you avoid entering a corporate integrity agreement (CIA), a mandatory compliance program imposed by the OIG. The terms and reporting requirements of a CIA

> *continued on p. 10*

Tips for jump-starting your compliance program

Compliance programs aren't mandatory, but they can protect your nursing facility from Office of Inspector General (OIG) investigations and other legal problems.

Mary Malone, Esq., a healthcare attorney at Hancock, Daniel, Johnson & Nagle, PC, in Richmond, VA, and **Betsy Anderson, BSA,** vice president of FR&R Healthcare Consulting, Inc., in Deerfield, IL, offered the following tips for facilities that want to implement a new compliance program or improve an existing one:

- **Read** the OIG's guidance documents. You can find the OIG's original compliance program guidance for nursing facilities, released in 2000, at *http://oig.hhs.gov/authorities/docs/cpgnf.pdf* and the supplemental guidance released in September 2008 by visiting *www.oig.hhs.gov* and clicking News Room under the Quick Links section. Click on the press release dated 9-30-2008 and scroll to the bottom of the document, where there is a link to the supplemental compliance.
- **Identify** areas that are particular risks for your facility, such as submission of accurate claims.
- **Customize** your compliance program for your facility's individual needs, rather than using a generic plan.
- **Integrate** compliance efforts into your facility's existing Medicare and quality assurance meetings, rather than adding meetings.
- **Involve** as many staff members as possible in compliance efforts and gain their support for your compliance program.

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Compliance

< continued from p. 9

are likely to be harsher than your own compliance program, Malone says.

Some facilities buy premade compliance plans from vendors, attorneys, or consultants. Using a template as a starting point is fine, but simply purchasing a generic compliance plan and placing your facility's name on it isn't a good idea, Malone says.

"Without tailoring the plan to your facility, it's hard to have ownership and buy-in to the program, and those are key elements of a successful compliance program," she says.

The impending CMS Recovery Audit Contractor program, which will use contractors to find and recover what are deemed improper Medicare payments to providers, may give nursing facilities another incentive to start focusing on compliance, Anderson says. If facilities aren't auditing their practices to ensure compliance with Medicare rules, the contractors may do so and require facilities to return Medicare payments.

Compliance program components

Most facilities' compliance programs will vary based on individual needs and resources, but all programs should include some common elements established by the OIG's guidelines, Malone says. According to the guidelines, a compliance program should contain:

- A code of conduct
- A compliance officer/committee
- Written policies and procedures to implement a compliance plan
- Training and education
- Auditing and monitoring
- A reporting mechanism (such as a hotline)
- A method to investigate and respond to detected noncompliance

Put compliance guidance in action

If implementing a compliance program seems daunting or you think your facility doesn't have the resources, keep in mind that compliance isn't an all-or-nothing proposition, Anderson says. She recommends that providers start by reading the OIG's guidance and identifying risk areas they want to address.

For example, if your facility has a large Medicare population, you might identify risks related to Medicare. Try to deal with your targeted risks within your current quality assurance framework.

Identify staff members who should be involved in facility compliance and incorporate compliance issues into existing Medicare and quality assurance meetings, rather than scheduling additional compliance meetings, Anderson says. If your facility's compliance committee includes administrators or other staff members who do not regularly attend Medicare meetings, invite them to the compliance portion of the meeting.

Nursing facilities developing or evaluating compliance programs may want to work with a consultant or attorney who is familiar with healthcare compliance issues, Malone says.

Involve as many staff members as possible, she adds. Without buy-in from your staff members, your compliance program won't succeed.

Achieving compliance is an ongoing effort, Anderson says. If you incorporate compliance into daily operations, your program is more likely to be successful. ■

MDS 3.0 question of the month

Q I am a case manager and I do our MDS here for our swing bed patients. Will the MDS 3.0 apply to swing beds? We are a rural hospital that can keep up to 10 swing bed patients.

To read Regulatory Specialist Diane Brown's answer to this question, visit *www.mdscentralonline.com.* Click on the Ask Diane icon and then on the Diane Brown link above her picture. Diane answered this question on December 19, 2008.

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PPS Q&A

Editor's note: "PPS Q&A" is written by ***Rena R. Shephard, MHA, RN, RAC-MT, C-NE,*** *founding chair and executive editor of the American Association of Nurse Assessment Coordinators and president of RRS Healthcare Consulting Services in San Diego. To submit a question, contact Associate Editor Emily Beaver at* ebeaver@hcpro.com.

Q Is it true that only a respiratory therapist can do the initial respiratory evaluation on a SNF resident? Also, please explain how to count the minutes when giving respiratory treatments.

A No, a nurse who has been trained in respiratory assessment and treatments can also do the initial and follow-up evaluations, as well as the treatments.

When counting minutes, include only the minutes that the trained nurse spends with the resident providing the treatment.

For example, you can count the minutes for the respiratory assessment you do prior to starting the treatment, and you can count the set-up time and the time getting the resident started on the treatment. But if the resident can take it from there without your help, you can't count any more time until you do the reassessment after the treatment and take the equipment away. If the resident needs you to stay to assist throughout the treatment, all of that time can be counted.

Q A consultant told me I'm not supposed to do ICD-9 coding since I'm not a certified coder. Also, for section I, Disease Diagnosis, do we need to put the aftercare diagnoses that physical and occupational therapy use as treatment diagnoses under that section? The consultant told me not to add these diagnoses because they are not in the history and physical or physician progress notes.

A There isn't a regulatory requirement that the person doing the ICD-9 coding be certified. Nurses are doing the coding in many nursing homes. However, ICD-9 coding is a specialty, and it is very different for nursing homes than it is for hospitals, so it is important that the person doing the coding be properly trained.

Any diagnosis that is entered in section I must be supported by a diagnosis from the physician, nurse practitioner, or physician assistant. When therapists write the telephone or fax order for the therapy orders, it is most likely that the diagnoses they are using are included there. If so, when the physician signs the order, that is all you need.

Q A resident has been in our facility on Medicaid since admission in 2005. She has had a tube feeding for 100% of her nutrition during her entire stay. She became eligible for Part A benefits in 2007. She just returned from the first three-day hospital qualifying stay since she became eligible for Medicare. My understanding is that she can't be covered on Part A in the SNF now because she has had a skilled level of care with the tube feeding all this time. Is this correct?

A No. Since she never used any Part A days, she has 100 days available, as long as she's had a three-day qualifying hospital stay and meets all other coverage criteria.

You might be thinking about a situation in which a resident has exhausted Part A benefits for a benefit period and continues to receive a skilled level of care in the SNF. In that case, even though Medicare is not the payer, the resident cannot earn a new 100-day benefit period until he or she goes for 60 consecutive days without an inpatient hospital admission and without receiving a skilled level of care in a SNF.

Once that 60-day break in skilled care occurs, then, if the resident has a three-day qualifying hospital stay at some point after that, he or she will earn a new 100-day SNF benefit period.

> continued on p. 12

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Q&A

< *continued from p. 11*

Q I am trying to understand the projection in section T. How can it be okay to bill for a category if the minutes haven't been provided? Also, if the projection shows that the resident will be getting enough minutes to reach the Rehab Very High category, why does the facility get paid at the Rehab High level?

A The projection, which covers the first 15 days of the Part A stay, allows the facility to be paid for the level of services the resident is expected to receive, even though that level of rehab might not be delivered during the seven-day observation period of section P1b.

The instructions for completing section T are in Chapter 3 of the *RAI User's Manual*. It explains the process for projecting therapy days and minutes for the first 15 days of the Medicare stay. The projection must be based on the treatment plan resulting from the evaluation. The process is as follows:

1. Look at the number of minutes/days of therapy documented in section P
2. Based on the treatment plan, project how much more therapy the resident is expected to receive from the day after the assessment reference date through day 15
3. Add the two together; that's your projection

Facilities should routinely audit the accuracy of projections by comparing them to the amount of therapy actually provided. At times, projected days/minutes will not be delivered because the resident was too tired or got sick. Most of the time, the projection should be fairly accurate or it probably isn't being done correctly. ■

Beneficiary notification quiz answer key

1. **A.** Although specific scenarios for use of the ABN in a SNF are still gray, the best choice in this case would be to inform the patient and family of the likely denial of payment from Medicare and review other payment options prior to admission.
2. **B.** The expedited review process is in addition to the Notice of Non-Coverage requirements.
3. **D.** No notice would be required since the resident is making her own decision to end Medicare coverage.
4. **A** and **C.** Both notices are required when a resident has benefits remaining and will be staying in the facility.

Questions? Comments? Ideas?

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